Maryland Chapter American College of Emergency Physicians

September 29, 2008

John M. Colmers, Secretary of Health & Mental Hygiene
Office of Secretary
Department of Health & Mental Hygiene
201 West Preston St.
Baltimore, MD 21201 - 2399

VIA EMAIL – HARD COPY TO FOLLOW

RE: Recommendations and Suggestions in response to the Task Force on Health Care Access and Reimbursement Document titled "Required Areas For Recommendation"

Dear Secretary Colmers and Members of the Task Force:

We are writing to provide you with our recommendations and suggestions regarding the work of the Task Force and the options that have been presented for discussion.

Who We Are:

Maryland ACEP represents the interests of emergency physicians and their patients throughout the State of Maryland. Our mission is the preservation of quality emergency care, patient advocacy, emergency medical training, and continuing education for emergency physicians, nurses, and technicians. The college promotes policy that preserves the integrity of emergency medicine.

As emergency physicians we are in the unique position of being on the front lines of Maryland's health care system. We proudly serve as the **safety net** providing care for everyone, including the poor, uninsured, and the disenfranchised. We cannot and do not deny care to anyone; all stabilizing medical care including x-rays, lab work and consulting of specialists cannot be delayed to inquire about methods of payment or of insurance coverage. Often times we may be a person's only source of medical care.

The Challenge:

Being at the front lines affords us a first hand view of how Maryland's health care system is operating. What we are seeing today and have been for the last 5 years is a fraying of the safety net. Increasing numbers of patients with more complex problems are coming to the emergency department every year, leading to long wait times and overcrowded emergency departments. This surge has been coupled with a steady decline in physician reimbursement, complicated by already high levels of uncompensated and undercompensated care.

We want to be clear that low physician reimbursement is most felt not in our own pockets but in the ability to safely staff our emergency departments. Inadequate reimbursement impedes our ability to recruit and retain trained emergency physicians; the results are unsafe staffing levels, substitution of midlevel providers for qualified emergency physicians, and the hiring of lower paid physicians who have not completed emergency medicine residencies. Maryland emergency departments are ripe for an incident like the one in the news article regarding the patient who died waiting in an ED in Texas. There is a national market in which we have to compete to bring in the best and the brightest physicians. In order to attract and retain these physicians we have to reshuffle our funding and staffing priorities and rely on subsidies and financial support from our hospitals to make up the difference in the low reimbursement.

Our Response:

We have looked at other states and how physicians are reimbursed: Maryland is an outlier. In Maryland we are faced with one of if not the lowest HMO rates in the country. The current system can no longer sustain itself. Without a meaningful solution patient access to care is going to suffer.

The prohibition on balance billing eliminates any leverage in negotiations with HMO's. We don't want to be non-par. But we have to be non-par when the rates do not come close to covering the costs of providing coverage and the HMO's refuse to negotiate because they don't need to: they get a great deal when we are non-par.

We have thoroughly examined all of the options outlined in the HCAR document handed out at the September 8th meeting. We have focused our comments to the following areas as detailed below. We urge the Task Force to give strong consideration to our suggestions and recommendations.

Non-Participating Provider Reimbursement in the HMO market - Options 3.1; 3.2; 3.2.1; 3.2.2

We need to move to a system where the HMO, not the physician, is responsible for unpaid charges, protecting and holding the subscriber harmless. This will give physicians the leverage they need to negotiate reasonable agreements with HMO's.

In a letter to the Task Force dated July 9th we provided examples of statutes and regulations from other states where there is the consumer protection against balance billing. Those states included New Jersey and Florida. We have since identified two other states Colorado and Virginia. In these states the responsibility is on the HMO, insurer or health plan to hold their subscribers harmless from balance billing.

They are not suffering to the extent that Maryland is in recruiting and retaining physicians. In these 4 states evidence suggests that there has not been an exodus of providers dropping contracts or refusing to contract, but the opposite: willingness to contract with the health plans due to a greater ability to negotiate a fair rate. There is no

indication that states with HMO laws mandating payment based upon charges have average charges that greatly exceed the national average. Rather charges continue to be developed based upon practice expenses.

During the 2006 and 2007 Legislative Sessions efforts were made to revise the methodology that is currently in statute (Health General 19-710.1). What became clear during those discussions is that there is **no** "one size fits" all revision that will provide the immediate and necessary relief.

The best and only way to provide relief in the HMO market across all specialties is to shift the responsibility of holding subscribers harmless from balancing billing to the HMO.

The inequity in the HMO market must be corrected before there is any action taken in the PPO market.

Link Designation of preferred hospitals to-Network Participation of Hospital-based Physicians - Option 3.3

We believe this option would allow payers to establish below market rates and continue to place hospitals in the position of having to provide subsidies in order to ensure the communities in which they serve continue to have access to quality healthcare.

It would further limit the ability for hospital based physicians to negotiate fair contractual rates.

This represents an unfair trade practice.

Develop hospital based payment system demonstration - Option 5.1

Currently there is no consensus among hospital based physicians as to the desirability of such a system. In discussions within our own college, it becomes clear that we simply do not know enough about what this might look like. Before any action is taken, we must better understand the implementation and consider both the clinical and economic impacts.

Encourage commercial payers to pay PCPs a premium for visits after the end of the 5:00pm work day and on weekends - Option 8.1

In addition to this option we would ask that commercial payers be encouraged to pay for these common after-hours service codes:

99050 which is "services provided in the office at times other than regularly scheduled office hours", and

99051 which is "services provided during regularly scheduled evening, weekend, or holiday office hours."

Additional Recommendations:

We feel that in addition to the issues discussed above the following essential initiatives need to be addressed:

Tort Reform – Malpractice costs remain high and add a continual economic burden to our system. Enactment of Good Samaritan protection for emergency physicians and providers of EMTALA mandated care would ease this burden.

Medical Home – As discussions continue regarding Medical Homes, it must include the safety net of emergency care.

Credentialing reform and IT improvements - Developing procedures that streamline and standardize the credentialing process; and adoption of a uniform IT format for electronic medical records and billing transactions

In Summary:

The purpose of the Task Force and its recommendations must be to bring Maryland more in line with other states and their levels of reimbursement in order to attract new physicians to the state and to retain those who have completed their medical schooling and training. There is a shortage of physicians in Maryland and there can only be access to care if physicians are here to treat the patients.

We strongly urge the Task Force to support our recommendation to reform the HMO non-participating reimbursement system to one that is based on the HMO taking responsibility for their subscriber being held harmless from balance billing.

We are ready to work with you, members of the task force, insurers and the other physician stakeholders on a solution moving in that direction.

Sincerely,

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